Yale HEALTH

Obstetrics and Gynecology

Name:

Age:

Date:

Please circle or fill in appropriate answer and include any details below:

1. How many times have you been pregnant?			21. My sexual partners have been:	Male	Female
2. How many children do you have?			22. Do you feel you might be at risk for a sexually transmitted infection (STI) (such as gonorrhea, Chlamydia, herpes, hepatitis, HIV)?	Yes	No
3. When did your last period begin?					
4. How many days from the start of one period to the start of the next period? Are you regular?			23. Have you ever had a sexually transmitted infection (STI) (such as gonorrhea, Chlamydia, herpes, hepatitis, HIV)?	Yes	No
5. How many days of bleeding do you have for each period?					
6. Do you have very heavy periods?	Yes	No	24. Do you eat a well-balanced diet, including several servings of fruits and vegetables each day?	Yes	No
7. Do you have painful periods?	Yes	No			
8. Do you have unusual or unexpected vaginal bleeding, including post-menopausal?	Yes	No	25. Do you restrict your diet in any way or not eat certain foods such as meat or dairy?	Yes	No
9. Have you had an unexpected change in your weight?	Yes	No	26. Do you make sure you're getting enough calcium?	Yes	No
10. Are you having any pelvic pain or discomfort?	Yes	No	27. Have you ever had an abnormal Pap or HPV?	Yes	No
11. Are you having any new changes or problems with urination (peeing)?	Yes	No	28. Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter?	Yes	No
12. Any changes or problems with bowel habits (pooping)?	Yes	No	29. Have you had any major life changes or stresses recently?	Yes	No
13. Any unusual vaginal discharge?	Yes	No	30. In the past year, have you had two weeks or more during which you felt sad, blue, or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?	Yes	No
14. Are you being affected by menopausal symptoms? If yes, circle those that apply: hot flashes, vaginal dryness/discomfort, mood changes	Yes	No	31. How many drinks of alcohol (beer, wine, liquor) do you have in an average week?		
16. Any breast lumps, pain or discharge?	Yes	No	32. Do you use tobacco? If yes, how many cigarettes a day? _____	Yes	No
17. Are you in a sexual relationship right now?	Yes	No	33. Do you use any recreational drugs?	Yes	No
18. Do you use birth control? Circle methods used: condoms, pills, IUD, ring, patch, DepoProvera, partner's vasectomy, or tubal ligation, or _____	Yes	No	34. Do you get more than 30 minutes of exercise at least 3 times per week?	Yes	No
			35. Are you planning to get pregnant in the next year?	Yes	No
19. Have you had a new sexual partner in the last year?	Yes	No	36. If you are 26 years old or younger, have you ever received the HPV vaccine?	Yes	No
20. Any concerns about sex (pain, change in interest or other problems)?	Yes	No			

Please briefly list any details or any other symptoms, health issues or risks that you are concerned about on the back.